MDR: M4-02-4516-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $529.59 for date of service, 02/19/02.

   b. The request was received on 07/10/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Position Statement taken from the Table of Disputed Services.
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Example EOBs from other insurance carriers
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 8/27/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/28/02. The response from the insurance carrier was received in the Division on 9/10/02. The insurance carrier's response is timely.

4. Notice of Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states on the Table of Disputed Services that, "We feel we are due an additional payment for the equipment we gave this patient. We have submitted all necessary documentation including examples of payments by other carriers. This carrier still denies additional payment."

2. Respondent: The Respondent states in a letter date stamped 09/10/92, "…Under Rule 133.304(i), if the insurance carrier pays a health care provider for a treatment or service for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall develop and consistently apply a methodology to determine the fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement. In this instance, the insurance carrier reimbursed the provider an amount computed under the Texas 2002 Medicare DME Schedule plus 20%, which it determined as a fair and reasonable rate. If the dispute involves health care for which the commission has not established a maximum allowable reimbursement, under Rule 133.307(g) (D), the provider is to submit documentation to discuss, demonstrate, and justify that the payment amount being sought is a fair and reasonable rate of reimbursement…."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 02/19/02.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $2,365.05 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $1,934.46 for services rendered on the dates of service in dispute above.

5. The Carrier denied payment for date of service 02/19/02 as "M Payment recommendation based on fair and reasonable which (Audit Company) has defined as the Texas 2002 Medicare DME Fee Schedule plus 20%.; O Previously recommended amount has not been changed.; F This service is included in another service performed on the same date.; M The amount charged exceeds the maximum usual and customary fee for the same service(s) in the same geographic area.; CODE 97500 IS DENIED BECAUSE THE TRAINING AND FITTING FEE IS DENIED AS INCLUSIVE WITHIN THE RENTAL AND PURCHASE OF THESE ITEMS. BLR."

6. The amount in dispute is $529.59 for services rendered on the date of service in dispute above.

7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
02/19/02	L0430 NU TLSO, anterior-posterior-lateral control, with interface material custom fitted E0143-NU Folding walker, wheeled, without seat	$1,800.00 $121.55	$1,458.56 $79.75	M, O For both codes	No MAR	MFG GI VIII	MFG GI VIII states "…NOTE: TWCC modifiers may differ from those published by the American Medical Association, and in submitting workers' compensation bulling, only the modifiers set out in this Medical Fee Guideline shall be used…" The modifier "NU" is not recognized in the '96 MFG. For this reason, the Medical Review Division is unable to determine proper reimbursement. Since "NU" is an unrecognized modifier, **no** additional reimbursement is recommended.
02/19/02	97500	$100.00	$0.00	F, O	$24.00	CPT Descriptor MFG MGR (A) (10) (d)	MFG MGR (10) (d) states, "The codes for orthotics (97500-97501) and prosthetics (97520-97521) training shall be used for instruction and training. The HCPCS codes shall be used for the custom fabrication of the orthosis or prosthesis." The Provider billed the correct CPT code for services rendered. Therefore, reimbursement in the amount of **$24.00 is recommended**.
02/19/02	L0510 LSO, flexible (lumbo-sacral surgical support), custom fabricated E0930 Fracture frame, freestanding, complete with grab bar	$300.00 $67.50	$292.70 $54.55	M, O For all codes	No MAR	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i); MFG DME GR IX (C); MFG DME GR VIII	The Carrier has denied the dates of disputed service, as "M-NO MAR SET BY THE TWCC-REDUCED TO FAIR AND REASONABLE". The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of "fair and reasonable" reimbursement. Since there is no MAR, the Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence as to whether the billed amount is fair and reasonable. The carrier reimbursed the Provider an amount computed under the Texas 2002 Medicare DME Schedule plus 20%, which they have determined as fair and reasonable. However, the Carrier failed to submit a copy of this schedule. Therefore, the Carrier has not submitted any evidence or the methodology it used to determine fair and reasonable reimbursement. The provider has submitted EOB's that does show some evidence of fair and reasonable. Therefore, additional reimbursement **is** recommended in the amount of **$20.25.**
02/19/02	E1399 Cold Therapy Cooler Wrap	$75.00	$49.00	M, O	No MAR	TWCC Act & Rules Sec. 413.011 (d)	The example EOBs (except for one) submitted did not specify the type of unclassified DME product used. Therefore, they were insufficient to support that the fee requested was fair and reasonable. Therefore, **no** additional reimbursement is recommended.
Totals		$2,365.05	$1,934.46				The Requestor **is** entitled to additional reimbursement in the amount of **$44.25.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $44.25 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 25th day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division
PD/pd